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[Qualitative Protocol]

Perceptions and experiences of labour companionship: a qualitative evidence synthesis

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ABSTRACT

This is a protocol for a Cochrane Review (Qualitative). The objectives are as follows:

The overall objective of the review is to describe and explore the perceptions and experiences of women, partners, community members, healthcare providers and administrators, and other key stakeholders who have experience with a labour companion. The review has the following objectives.

1. To identify, appraise and synthesise qualitative research evidence on women's, partners', community members', healthcare providers' and administrators', and other key stakeholders' perceptions and experiences regarding labour companionship in health facilities.

2. To identify barriers and facilitators to successful implementation and sustainability of labour companionship.

3. To explore how the findings of this review can enhance our understanding of the related intervention review (Hodnett 2013).

BACKGROUND

Women have traditionally been attended by a companion in labour, but initiatives to increase the number of women giving birth in health facilities have not necessarily respected this tradition. A Cochrane effectiveness review by Hodnett and colleagues (Hodnett 2013) concluded that having a labour companion improves outcomes for women, yet this basic, inexpensive intervention is far from universal. There is also a global interest in improving the quality of maternal and newborn care, including to "initiate, support and sustain programs designed to improve the quality

of maternal health care" (World Health Organization 2014). This includes a strong focus on respectful care as an essential component of quality of care. The presence of a labour companion is therefore regarded as an important aspect of improving quality of care during labour and childbirth.

The Hodnett 2013 review measured the effectiveness of continuous support during labour, including the following subgroup analyses: (1) characteristics of the childbirth environment (policies that allow or prohibit having a support person of choice, availability of epidural analgesia and availability of routine electronic fetal heart rate monitoring); and (2) characteristics of providers of labour support (staff members of the hospital, neither hospital staff members nor part of the woman's social network, and chosen by the woman from her social network). Subgroup analyses on the characteristics of providers of labour support suggested that all types of supporters were effective, but some were more effective than others, depending on the outcome of interest. For example:

- continuous support had an effect on use of any intrapartum analgesia/anaesthesia, when the supporter was a member of hospital staff (risk ratio (RR) 0.97, 95% confidence interval (CI) 0.96 to 0.99) or part of a woman's social network (RR 0.91, 95% CI 0.86 to 0.97); and
- continuous support did not have an effect on reducing the likelihood of dissatisfaction with or negative views of childbirth, when the supporter was a member of hospital staff (RR 0.87, 95% CI 0.73 to 1.03), but was significant when the supporter was part of the woman's social network (RR 0.57, 95% CI 0.51 to 0.64) or neither hospital staff nor part of the woman's social network (RR 0.66, 95% CI 0.57 to 0.77).

In addition to influencing women's satisfaction with care, providing labour companionship may also influence the social dynamic between the woman and the healthcare provider, including behaviours that could be classified as mistreatment during childbirth.

Following a technical meeting held at the World Health Organization in August 2015, it was noted that implementation of labour companionship may be hampered by a lack of understanding of the barriers and facilitators to successful implementation, especially in low- and middle-income countries (LMICs). In these settings, qualitative research on labour companionship could provide more in-depth understanding of factors influencing effective implementation, including shedding light on:

- the differences in the nature, degree, acceptability and contextual operation of labour companionship provided by professional labour companions when compared to lay labour companions;
- characteristics and features of labour companionship in settings where it is working well and less well, including barriers and facilitators to implementation and sustainability;
- women's perceptions and experiences of labour companionship;
- partners' or other community members' perceptions and experiences of labour companionship; and
- healthcare providers' perceptions and experiences of labour companionship.

In the Hodnett 2013 review, continuous support is defined as "continuous presence and support during labor and birth. The person providing the support could have qualifications as a healthcare professional (nurse, midwife) or training as a doula or childbirth educator, or be a family member, spouse/partner, friend or stranger with little or no special training in labor support" (Hodnett 2013). In this review, we use the term 'labour companionship' to describe support provided to a woman during labour and childbirth, in order to cover the full spectrum of contexts and situations in which women may be accompanied and supported during labour. For example, in certain settings, labour companionship may not be allowed 'continuously' throughout labour and childbirth, but may be allowed 'intermittently' (e.g. during labour but not during the birth). In this review, the person providing labour companionship may be any of the people described by Hodnett 2013, including a healthcare professional, doula, childbirth educator, family member, spouse/partner, friend or stranger.

1. Description of the phenomenon of interest

The phenomena of interest in this review are the perceptions and experiences of companionship during labour and childbirth of women, partners, community members, healthcare providers and administrators, and other key stakeholders. We define labour companionship as any person providing any type of support to a woman during childbirth. This could include "emotional support (continuous presence, reassurance and praise), information about labor progress and advice regarding coping techniques, comfort measures (such as comforting touch, massage, warm baths/showers, promoting adequate fluid intake and output) and advocacy (helping the woman articulate her wishes to others)" (Hodnett 2013). The following are examples of relevant studies.

1. Women, labour companions and health worker's views on acceptability and experiences of the introduction of a woman's companion of choice during the duration of labour and childbirth in Malawi (Banda 2010).
2. Healthcare providers' perceptions of labour management in the presence of a woman's companion of choice, and labour companions' perceptions of their experience in Brazil (Bruggemann 2007).
3. Women, female family members and healthcare providers' perceptions and acceptability of labour companionship at public teaching hospitals in Lebanon, Syria and Egypt (Kabakian-Khasholian 2015).

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4. Student midwives' experiences of and lessons learned from offering continuous labour support to women during childbirth in Sweden (Thorstensson 2008).

2. Why is it important to do this review?

A qualitative evidence synthesis (QES) on labour companionship could help researchers, administrators, and programmers to better understand how to implement a labour companionship program effectively, and could also act as a "companion" review to the Hodnett 2013 review. Synthesising and appraising the qualitative evidence of the perceptions and experiences of labour companionship from the perspectives of healthcare providers, women, partners, community members, and other relevant stakeholders would address why and how different ways of providing labour companionship, in different contexts, are most likely to deliver optimum benefits for women and babies.

OBJECTIVES

The overall objective of the review is to describe and explore the perceptions and experiences of women, partners, community members, healthcare providers and administrators, and other key stakeholders who have experience with a labour companion. The review has the following objectives.

1. To identify, appraise and synthesise qualitative research evidence on women's, partners', community members', healthcare providers' and administrators', and other key stakeholders' perceptions and experiences regarding labour companionship in health facilities.

2. To identify barriers and facilitators to successful implementation and sustainability of labour companionship.

3. To explore how the findings of this review can enhance our understanding of the related intervention review (Hodnett 2013).

METHODS

1. Criteria for considering studies for this review

Types of studies

We will include primary studies that use qualitative methods for data collection (e.g. interviews, focus group discussions, observations), and that use qualitative methods for data analysis (e.g. thematic analysis, grounded theory). We will exclude primary studies that collect data using qualitative methods but do not perform a qualitative analysis (e.g. open-ended survey questions where responses are analysed using descriptive statistics). Mixed methods studies will be included when it is possible to extract data resulting from qualitative methods. Qualitative studies do not need to be linked to effectiveness studies included in the relevant Cochrane review, and do not need to be linked to an intervention.

Types of participants

We will include studies that focus on the perceptions and experiences of:

- women, including those who have had an experience of labour companionship and those who have not;
- partners or other community members who have provided labour support or could potentially provide labour support in the future;
- all cadres of healthcare providers (e.g. doctors, nurses, midwives, lay health workers, doulas) who are involved in providing healthcare services to patients; and
- other relevant stakeholders involved in providing or organising care, including administrators and policy-makers.

Settings

We will include studies of labour companionship in any country and in any type of health facility (e.g. health clinics, hospitals, midwife-led clinics). We will include studies published in English, French, Spanish, Turkish, Norwegian and Portuguese, based on the language abilities of the review team. Additional languages will be included if appropriate translators can be identified.

Phenomena of interest

The phenomena of interest in this review are the perceptions and experiences of labour companionship during childbirth in health facilities, of women, partners, community members, healthcare providers and administrators, and other key stakeholders. This includes factors that may influence the feasibility, acceptability and sustainability of implementing a labour companionship intervention.

2. Search methods for the identification of studies

Electronic searches

We will search the following electronic databases for eligible studies:

- CINAHL EbscoHost;
- MEDLINE Ovid; and

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- POPLINE K4Health.

We will develop search strategies using guidelines developed by the Cochrane Qualitative Research Methods Group for searching for qualitative evidence (Noyes 2011) (see Appendix 2 for the MEDLINE search strategy). We chose these databases as we anticipate that they will provide the highest yield of relevant results based on preliminary, exploratory searches.
There are no language, date or geographic restrictions for the search.

Searching other sources

In addition to database searching, we will search references of all included studies and other key references ,e.g. references identified in the Hodnett 2013 review. Key articles cited by many authors will be checked on Google Scholar to see if they were cited by any additional relevant papers.
OpenGrey (www.opengrey.eu/) and The Grey Literature Report (www.greylit.org/) will be used to search for relevant grey literature.
We will contact key researchers working in the field for additional references or unpublished materials (including, but not limited to: Tamar Kabakian, Lynn Freedman, Kate Ramsey and Mary Ellen Stanton).

3. Data collection and analysis

Selection of studies

Titles and abstracts identified through the database searches will be exported into one reference database, and duplicates will be removed. Two independent review authors will assess each record for its eligibility for inclusion according to predefined criteria. References that do not meet the inclusion criteria will be excluded. Full-text articles will be retrieved for studies included after title and abstract screening. Two independent review authors will assess each full text for its eligibility for inclusion according to predefined criteria. Disagreements between review authors will be resolved through discussion and/or a third author. If necessary, study authors may be contacted for more information to determine study eligibility.
This QES aims for both variation in concepts and depth of understanding of emergent themes, rather than an exhaustive overview of every study. As such, if more than approximately 40 articles are eligible for inclusion, we may use maximum variation purposive sampling to select studies. Key areas of variation may include type of participant (healthcare provider versus user), geographical setting, country income level, and link to an intervention study. If a sampling approach is used, then we will continue to sample studies using the constant comparative method until the themes arising from the included data are saturated, including any disconfirming data.

Data extraction and management

Data will be extracted from included studies using an Excel form designed for this review. This form will include information about the study setting, sample characteristics, objectives, guiding framework, design, data collection and analysis methods, qualitative themes, qualitative findings, supporting quotations, conclusions, and any relevant tables, figures or images.

4. Assessment of risk of bias of included studies

Appraisal of study quality

To be eligible for inclusion in this review, studies must use qualitative methods for data collection and data analysis. The quality of included studies will be appraised using an adaptation of the CASP tool (www.casp-uk.net), and will include the following domains: aims, methodology, design, recruitment, data collection, data analysis, reflexivity, ethical considerations, findings, and research contribution. Two independent review authors will critically appraise the included studies using this form. Disagreements between review authors will be resolved through discussion and/ or a third author.
Critical appraisal is a component of the assessment of confidence for each review finding. Critical appraisal will not be used as a basis for exclusion.

Appraisal of the confidence in the review findings

We will use the CERQual (Confidence in the Evidence from Reviews of Qualitative research) approach to assess the confidence we have in the findings from included studies. This approach, building on the GRADE tool for Cochrane effectiveness reviews, is a work in progress, but is becoming the standard to assess the confidence in the findings from qualitative evidence syntheses (Bohren 2015; Colvin 2013; Lewin 2015; Munabi-Babigumira 2015; Odendaal 2015).The CERQual approach assesses the following four concepts.

1. Methodological limitations of included studies: this refers to the extent to which there are weaknesses in the design or methodology of studies that contributed evidence to a review finding. Confidence in a finding may be lowered by substantial methodological limitations.
2. Relevance of the included studies to the review question: this refers to the extent to which the primary studies supporting a review findings are applicable to the context (setting, participants, and phenomenon of interest) specified in the review question. Confidence in a finding may be lowered when contextual issues in a primary study used to support a review finding are different to the context of the review question.
3. Coherence of the review finding: this points to the extent to which there are patterns identified across the review findings

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contributed by each included study. This can be where a review finding is consistent across more than one context, or a finding that includes an explanation/s for variation/s across studies. Variations in data across the included studies without convincing and cogent explanations may lower the confidence in a review finding.

4. Adequacy of the data contributing to a review finding: this refers to an assessment of the level of richness, scope and quantity of data that support a review finding. Confidence in a finding may be lowered if a finding is supported by results from only one or a few of the included studies, or when the data supporting a finding are very thin.

The above assessments will result in an assessment of the overall confidence in each review finding as high, moderate, low or very low. Qualitative review findings and CERQual assessments will be presented in a 'Summary of qualitative findings' table and 'Evidence profile' that summarises the finding, overall confidence assessment, and rationale for assessment of each finding.

5. Data synthesis

We will use a framework thematic synthesis approach, as described by Thomas and Harden (Thomas 2008). Thematic synthesis is a useful approach to analyse data from qualitative evidence syntheses exploring people's perspectives and experiences, acceptability, appropriateness, and factors influencing implementation (Thomas 2008. This is comprised of familiarisation with and immersion in the data, free line-by-line coding of the findings of primary studies, organisation of free codes into related themes and development of descriptive themes, and development of analytical themes and interpretations to generate further concepts, understandings and hypotheses (Thomas 2008). We will use a modified SURE framework (SURE Collaboration 2011) as an a priori framework to help identify and categorise barriers and facilitators to implementing labour companionship as an intervention (Glenton 2013). The SURE framework will provide us with a comprehensive list of factors that could influence the implementation of labour companionship, and will help to integrate the findings of this synthesis with the effectiveness review (Hodnett 2013).

The first author will select an article that is highly relevant to the review question and use this article as the basis for the code list. Codes will first be structured as 'free' codes with no established link between them. These codes will be tested on a further three articles, to determine if and how well the concepts translate from one study to another. This will further develop the codebook, and new codes will be added as necessary. Review authors will seek similarities and differences between the codes and group the codes according to a hierarchical structure. If new codes arise throughout the analysis process, studies already coded will be revisited to determine if the new codes apply or not. At least two review authors will code the findings, and work as a team to generate analytical themes.

Included studies will be coded using Atlas.ti. This will help in the analysis as the review team will develop primary document families to organise groups of studies based on common attributes. It will also be used to restrict code-based searches, to filter coding outputs and to assist in subgroup analyses. For example, primary document families may include:

- type of participant (midwife, doctor, healthcare administrator, woman);
- setting (type of hospital);
- geographical location (regional or country-specific, if applicable);
- country income level (high, middle, low);
- type of labour companion described (doula, health worker, companion of choice, family member, husband); and
- type of qualitative study (associated with an intervention or stand-alone study).

This will allow the review team to hypothesise what factors shape the perceptions and experiences of women, healthcare providers and administrators. Potential areas for subgroup analyses include the following.

- Are perceptions and experiences different across different types of healthcare providers? For example, midwives versus doctors acceptability of allowing labour companions during facility-based childbirth.
- Are perceptions and experiences different by type of hospital? For example, private health facilities versus primary health centres versus tertiary health facilities.
- Are perceptions and experiences different across geographical locations? For example, sub-Saharan Africa versus southeast Asia versus Latin America.
- Are perceptions and experiences different across country income levels? For example, findings from low-income countries versus high-income countries.
- Are there preferences for the type of labour companion? For example: doulas versus family members versus health workers?

Supplementing the Cochrane effectiveness review with synthesised qualitative findings

This QES will be conducted in parallel to the update of the effectiveness review (Hodnett 2013), but the methods and results will be presented as an independent review. The findings from this review can be used to explain and contextualise the findings from the effectiveness review, and may help to identify hypotheses for future subgroup analyses. The review team will test the appropriateness of developing a logic model (see Glenton 2013) to link qualitative findings on preferences for labour companionship to outcomes described in the effectiveness review.

Researchers' reflexivity

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The perspectives of the review authors regarding subject expertise, employment, perspectives of labour companionship, and other background factors may affect the manner in which we collect, analyse and interpret the data. At the outset of this review, all authors believed that labour companionship was valuable to improve women's experiences of care, but that critical barriers exist to successful implementation of labour companionship, particularly in LMICs. In many contexts of facility-based birth, the provision of clinical procedures and assessments is considered the pinnacle of care, and women's experiences of care, including labour companionship and respectful care, are often forgotten. To minimise the risk that our perspectives as authors influence the analysis and interpretation, we will use refutational analysis techniques, such as exploring and explaining contradictory findings between studies. We will account for these differences, and any other issues that may contribute to the interpretation of the review findings, by describing it in a 'Reflexivity' section when publishing the protocol and review results.

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* *Indicates the major publication for the study*

APPENDICES

Appendix 1. Other related reviews

Cochrane reviews
Hodnett 2013 (*effectiveness review*) Munabi-Babigumira 2015 (*qualitative evidence synthesis*)
Non-Cochrane effectiveness reviews
Kabakian-Khasholian under review Beake ongoing (*in progress*)
Literature reviews

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(*Continued*)

Knape 2013 Rosen 2004 Steel 2015

Appendix 2. MEDLINE search strategy

Epub Ahead of Print, In-Process & Other Non-Indexed Citations, MEDLINE Daily and MEDLINE 1946 to Present, Ovid

#	Searches
1	Perinatal Care/
2	Obstetric Nursing/
3	Delivery, Obstetric/
4	Labor, Obstetric/
5	Parturition/
6	Home Childbirth/
7	Natural Childbirth/
8	or/1-7
9	Social Support/
10	8 and 9
11	Doulas/
12	(doula or doulas or obstetric nursing).ti,ab,kf.
13	((childbirth? or birth? or labor or laboring or labour or labouring or intrapartum) adj6 (support* or companion* or coach*)).ti,ab,kf
14	(((presence or present or attend* or accompan*) adj3 (family member? or friend? or spouse? or partner? or unskilled)) and (childbirth? or birth? or labor or labour)).ti,ab,kf
15	(((presence or present or attend* or accompan*) adj3 (midwife or midwives or midwifery or nurse)) and (childbirth? or birth? or labor or labour)).ti,ab,kf
16	or/11-15
17	10 or 16

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(*Continued*)

18	limit 17 to “qualitative (best balance of sensitivity and specificity)”
19	qualitative research/
20	17 and 19
21	18 or 20

HISTORY

Protocol first published: Issue 12, 2016

Date	Event	Description
5 October 2016	Feedback has been incorporated	Final revision to “reflexivity” section.
24 September 2016	Feedback has been incorporated	Updated with responses to peer review comments from SD, DH and CG
19 April 2016	Amended	Draft protocol with feedback from authors.

CONTRIBUTIONS OF AUTHORS

Led by Meghan Bohren, the review was collectively conceptualised by the full author team. Meghan Bohren drafted the first version of this protocol. All authors reviewed and commented on all drafts of this protocol.

DECLARATIONS OF INTEREST

Meghan Bohren is also leading the update of the effectiveness review “Continuous support for women during childbirth” (Hodnett 2013).

SOURCES OF SUPPORT

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Internal sources

- No sources of support supplied

External sources

- Department of Reproductive Health and Research, World Health Organization, Switzerland.
Other

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